Bureau of Ambulatory Care -- Missouri Radiation Control Program
Registration of Radiation Machines

rev 03.13.13

PO Box 570, 920 Wildwood, Jefferson City MO 65102 Phone (573) 751-6083, FAX (573) 751-6158

DHSS MRCP-Assigned Registration #		*Complete all fields below (even if N/A) and fax or email form to* ***MRCP@health.mo.gov***		
Facility Name:			Telephone #	
Facility Address:			Facility Fax#	
City, State, Zip		County	E-mail	
Owned by/Parent Facility/Company:				
Primary Responsible Person(Rad Safety Officer/Radiology Manager or facility owner):				
If No RSO/Rad Manager is named above, list physicians associated with radiation procedures for this facility, or name of radiology group.				
Physicians/Group:				

Facility Radiation Procedure Workload, Image Processing, and Equipment Operators

Average of total radiation exposures per month for this facility:		*(Approx. total radiation exposures per year:)*	***0***
Most common procedure or exam:		>This procedure is __% of all radiation exposures made?	
2nd most common procedure or exam:		>This procedure is __% of all radiation exposures made?	
Image processing/acquisition method:		Physicist/Qualified Expert:	
Routine personnel radiation monitoring (dosimeters) provided? (Y/N)		If Yes, # of staff monitored? (include students, area monitors, etc)	
Radiation Equipment Operators		**Total number of people operating radiation equipment at this facility:**	
Minimum training in radiation procedures/radiation safety for usual/typical facility operator:			

Radiation Producing Equipment Listing

Total number radiation machines at this facility:

Location/Room# of Machine	Type/Usage of Machine	Manufacturer	Control Model	Control Serial Number
Mach A.				
Mach B.				
Mach C.				
Mach D.				
Mach E.				
Mach F.				
Mach G.				
Mach H.				
Mach I.				
Mach J.				
Mach K.				
Mach L.				

Use Area below for any needed **explanatory comments**. If more than 12 machines are owned by facility, continue on Tab 2-Additional Machines list.

I hereby certify that I am the facility owner, or an employee/agent authorized and directed to complete this form accurately: ☐ Electronic signature

Facility Contact Certifying This Form:	Title:	Date: